

Inspection Report

Name of Service: Cornfield Care Centre
Green Lane and Castle Lane Suites

Provider: Cornfield Care Centre

Date of Inspection: 7 October 2025

Information on legislation and standards underpinning inspections can be found on our website <https://www.rqia.org.uk/>

1.0 Service information

Organisation/Registered Provider:	Cornfield Care Centre
Responsible Individual:	Mr Marcus Jervis Nutt
Registered Manager:	Mrs Claire Gormley
<p>Service Profile: Cornfield Care Centre (Green Lane and Castle Lane Suites) is a registered nursing home, which provides nursing care for up to 52 patients. The home is divided in two units over one ground floor level. Castle Lane provides care for patients living with dementia and Green Lane provides care under the general category of nursing care.</p> <p>A separately registered nursing home, Cornfield Care Centre (Kingfisher, Nightingale and Goldfinch suites), shares the site.</p>	

2.0 Inspection summary

An unannounced inspection took place on 7 October 2025, from 10.35am to 4.10pm. The inspection was completed by a pharmacist inspector and focused on medicines management within the home.

The inspection was undertaken to evidence how medicines are managed in relation to the regulations and standards and to determine if the home is delivering safe, effective and compassionate care and is well led in relation to medicines management. The area for improvement identified at the last medicines management inspection, was also reviewed. The areas for improvement identified at the last care inspection, were carried forward for review at the next inspection.

Mostly satisfactory arrangements were in place for the safe management of medicines. Medicines were stored securely. Medicine records and medicine related care plans were well maintained. There were processes in place to ensure that staff were trained and competent to manage medicines. There was evidence that the majority of medicines were administered as prescribed, a new area for improvement was identified in relation to ensuring that all medicines are administered as prescribed. An area for improvement in relation to medicines with a shortened expiry date, once opened, was stated for a second time.

Details of the inspection findings, including areas for improvement carried forward for review at the next inspection and areas for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) (Section 4.0).

Patients were observed to be relaxed and comfortable in the home and in their interactions with staff. It was evident that staff knew the patients well.

RQIA would like to thank the staff for their assistance throughout the inspection.

3.0 The inspection

3.1 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how the home was performing against the regulations and standards, at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection, information held by RQIA about this home was reviewed. This included areas for improvement identified at previous inspections, registration information, and any other written or verbal information received from patients, relatives, staff or the commissioning trust.

Throughout the inspection process, inspectors seek the views of those living, working and visiting the home; and review/examine a sample of records to evidence how the home is performing in relation to the regulations and standards.

3.2 What people told us about the service and their quality of life

Staff expressed satisfaction with how the home was managed. They also said that they had the appropriate training to look after patients and meet their needs. They said that the team communicated well and the management team were readily available to discuss any issues and concerns should they arise.

Staff advised that they were familiar with how each patient liked to take their medicines and medicines were administered in accordance with individual patient preference. Staff also said that they prioritised patients who required pain relief and time-critical medicines during each medicine round.

RQIA received five completed patient questionnaires during the inspection. These were positive regarding the management of medicines and the care received.

No responses to the staff survey were received following the inspection.

3.3 Inspection findings

3.3.1 What arrangements are in place to ensure that medicines are appropriately prescribed, monitored and reviewed?

Patients in nursing homes should be registered with a general practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times patients' needs may change and therefore their medicines should be regularly monitored and reviewed. This is usually done by a GP, a pharmacist or during a hospital admission.

Patients in the home were registered with a GP and medicines were dispensed by the community pharmacist.

Personal medication records were in place for each patient. These are records used to list all of the prescribed medicines, with details of how and when they should be administered. It is important that these records accurately reflect the most recent prescription to ensure that medicines are administered as prescribed and because other healthcare professionals, for example, may use them at medication reviews or hospital appointments.

The personal medication records reviewed were accurate and up to date. In line with best practice, a second member of staff had checked and signed the personal medication records when they were written and updated to confirm that they were accurate. A small number of minor discrepancies were highlighted for immediate corrective action and on-going vigilance.

Copies of patients' prescriptions/hospital discharge letters were retained so that any entry on the personal medication record could be checked against the prescription.

All patients should have care plans that detail their specific care needs and how the care is to be delivered. In relation to medicines, these may include care plans for the management of distressed reactions, pain, modified diets etc.

The management of distressed reactions, pain, thickening agents, insulin, antibiotics and epilepsy was reviewed. Care plans contained sufficient detail to direct the required care. Medicine records were well maintained. The audits completed indicated that these medicines were administered as prescribed.

3.3.2 What arrangements are in place to ensure that medicines are supplied on time, stored safely and disposed of appropriately?

Medicine stock levels must be checked on a regular basis and new stock must be ordered on time. This ensures that the patient's medicines are available for administration as prescribed. It is important that they are stored safely and securely so that there is no unauthorised access and disposed of promptly to ensure that a discontinued medicine is not administered in error.

Records reviewed showed that medicines were available for administration when patients required them. Staff advised that they had a good relationship with the community pharmacist and that medicines were supplied in a timely manner.

The medicine storage areas were observed to be securely locked to prevent any unauthorised access. They were tidy and organised so that medicines belonging to each patient could be easily located. Temperatures of medicine storage areas were monitored and recorded to ensure that medicines were stored appropriately. Satisfactory arrangements were in place for medicines requiring cold storage, the storage of controlled drugs and the safe disposal of medicines.

3.3.3 What arrangements are in place to ensure that medicines are appropriately administered within the home?

It is important to have a clear record of which medicines have been administered to patients to ensure that they are receiving the correct prescribed treatment.

A sample of the medicines administration records was reviewed. Records were found to have been accurately completed. Records were filed once completed and were readily retrievable for audit/review.

Controlled drugs are medicines that are subject to strict legal controls and legislation. They commonly include strong painkillers. The receipt, administration and disposal of controlled drugs should be recorded in the controlled drug record book. There were satisfactory arrangements in place for the management of controlled drugs.

Management and staff audited the management and administration of medicines on a regular basis within the home. There was evidence that the findings of the audits completed, had been discussed with staff and addressed. The date of opening was recorded on medicines to facilitate audit, however some eye drops and one external preparation, which have a shortened expiry date once opened, remained in use after expiry. This should be monitored on an ongoing basis within audit procedures. An area for improvement identified at the last medicines management inspection, was stated for a second time.

3.3.4 What arrangements are in place to ensure that medicines are safely managed during transfer of care?

People who use medicines may follow a pathway of care that can involve both health and social care services. It is important that medicines are not considered in isolation, but as an integral part of the pathway, and at each step. Problems with the supply of medicines and how information is transferred put people at increased risk of harm when they change from one healthcare setting to another.

A review of records indicated that satisfactory arrangements were in place to manage medicines at the time of admission or for patients returning from hospital. Written confirmation of prescribed medicines was obtained at or prior to admission and details shared with the GP and community pharmacy. Medicine records had been accurately completed and there was evidence that these medicines were administered as prescribed.

3.3.5 What arrangements are in place to ensure that staff can identify, report and learn from adverse incidents?

Occasionally medicines incidents occur within homes. It is important that there are systems in place, which quickly identify that an incident has occurred so that action can be taken to prevent a recurrence and that staff can learn from the incident. A robust audit system will help staff to identify medicine related incidents.

Management and staff were familiar with the type of incidents that should be reported. The medicine related incident which had been reported to RQIA since the last inspection was discussed. There was evidence that the incident had been reported to the prescriber for guidance, investigated and the learning shared with staff in order to prevent a recurrence.

The audits completed at the inspection indicated that the majority of medicines were being administered as prescribed. However, audit discrepancies were observed in the administration of a small number of medicines, including liquid and inhaler preparations. These were discussed in detail with the nurses on duty and management for on-going monitoring. An area for improvement was identified.

3.3.6 What measures are in place to ensure that staff in the home are qualified, competent and sufficiently experienced and supported to manage medicines safely?

To ensure that patients are well looked after and receive their medicines appropriately, staff who administer medicines to patients must be appropriately trained. The registered person has a responsibility to check that staff are competent in managing medicines and that they are supported. Policies and procedures should be up to date and readily available for staff reference.

There were records in place to show that staff responsible for medicines management had been trained and deemed competent. Medicines management policies and procedures were in place.

It was agreed that the findings of this inspection would be discussed with staff to facilitate the necessary improvements.

4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with Regulations.

	Regulations	Standards
Total number of Areas for Improvement	2*	2*

* the total number of areas for improvement includes one that has been stated for a second time and two which were carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with the Operations Director, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005	
<p>Area for improvement 1</p> <p>Ref: Regulation 13 (4)</p> <p>Stated: Second time</p> <p>To be completed by: Immediately and ongoing (7 October 2025)</p>	<p>The registered person shall ensure that a regular system of date checking is in place to ensure that medicines are not administered after their expiry date.</p> <p>Ref: 2.0 & 3.3.3</p> <p>Response by registered person detailing the actions taken: Nursing meeting held on 15.10.25. Discussed the importance of ensuring expiry dates on medication are checked prior to administration. Audit books have been implemented regarding eye drops, inhalers and will be monitored weekly by Sister of the unit. Random audits to be completed by Home Manager.</p>
<p>Area for improvement 2</p> <p>Ref: Regulation 13 (4)</p> <p>Stated: First time</p> <p>To be completed by: Immediately and ongoing (7 October 2025)</p>	<p>The registered person shall ensure that all medicines are administered as prescribed and those detailed in the report are monitored within audit procedures.</p> <p>Ref: 3.3.5</p> <p>Response by registered person detailing the actions taken: Audit book implemented for inhalers. Weekly checks to be completed by Sister of the unit. Home Manager to complete random checks to ensure all medications are administered as prescribed.</p>
Action required to ensure compliance with the Care Standards for Nursing Homes, December 2022	
<p>Area for improvement 1</p> <p>Ref: Standard 4.9</p> <p>Stated: First time</p> <p>To be completed by: 29 August 2024</p>	<p>The registered person shall ensure that the evaluation of patients care plans are meaningful and person centred.</p> <p>The care plans reviewed, regarding the management of medicines, were up to date and person centred, however this area for improvement was not fully reviewed.</p> <p>Action required to ensure compliance with this standard was not fully reviewed as part of this inspection and this is carried forward to the next inspection.</p> <p>Ref: 2.0</p>

<p>Area for improvement 2</p> <p>Ref: Standard 46</p> <p>Stated: First time</p> <p>To be completed by: 29 August 2024</p>	<p>The registered person shall ensure that staff are bare below the elbow in keeping with IPC best practice.</p>
	<p>Staff observed during the inspection were bare below the elbow; however, this area for improvement was not fully reviewed.</p> <p>Action required to ensure compliance with this standard was not fully reviewed as part of this inspection and this is carried forward to the next inspection.</p> <p>Ref: 2.0</p>



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